Appendix 1
Sample Completed HCFA 1500 Claim Form
(Occupational Therapy)

APPROVED OMB-0938-0008

PICA — **HEALTH INSURANCE CLAIM FORM** — PICA

CARRIER

1. MEDICARE (Medicare #) | MEDICAID [T] (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Im A.

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY — SEX: M [ ] F [x]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 609 Willow St.

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown — STATE: WI

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY — STATE

ZIP CODE: 55555 — TELEPHONE (Include Area Code): (XXX) XXX-XXXX

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE — TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI-P

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: M-7

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY — SEX: M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX: M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM — TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: I. M. Referring

17a. I.D. NUMBER OF REFERRING PHYSICIAN: B12345

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM — TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [X] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 435.9 — 3. _____

2. 437.0 — 4. _____

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 1234567

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 02 03 98	02 08 98	7	1	97150	OT	1	XXX XX	8.0				12345600
2 02 23 98		7	1	97110	OT	2	XXX XX	2.0				12345600
3 02 01 98		7	1	Q0109	OT	1	XXX XX	1.0				12345600
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ] — 26. PATIENT'S ACCOUNT NO. — 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ] — 28. TOTAL CHARGE $ XXX XX — 29. AMOUNT PAID $ XX XX — 30. BALANCE DUE $ XXX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

I.M. Authorized — MM/DD/YY

SIGNED — DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

I.M. Nursing Home
506 Willow
Anytown, WI 55555

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M. Billing
1 W. Williams
Anytown, WI 55555 86754321

PIN# — GRP#

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) — ***PLEASE PRINT OR TYPE*** — FORM HCFA 1500 (12 90) FORM OWCP-1500 FORM RRB-1500

Appendix 1a
Sample Completed HCFA 1500 Claim Form
(Rehabilitation Agency)

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER
(Medicare #) M (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Im A.

3. PATIENT'S BIRTH DATE MM DD YY / SEX: MM DD YY M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 609 Willow

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown — STATE: WI

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY — STATE

ZIP CODE: 55555 — TELEPHONE (Include Area Code): (XXX) XXX-XXXX

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE — TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI-P

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: M-7

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) [ ] YES [ ] NO

a. INSURED'S DATE OF BIRTH MM DD YY / SEX: M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX: M [ ] F [ ]

b. AUTO ACCIDENT? [ ] YES [ ] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? [ ] YES [ ] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM — TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: I.M. Referring MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: B12345

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM — TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 435.9
2. 437.0
3.
4.

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 1234567

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 02 03 98	02 08 98	7	9	97112	OT	1	XXXX	8.0				
2 02 23 98		7	9	97770	OT	2	XXXX	2.0				
3 02 01 98		7	9	Q0109	OT	1	XXXX	1.0				
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN [ ] [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [ ] YES [ ] NO

28. TOTAL CHARGE $ XXX.XX

29. AMOUNT PAID $ XX.XX

30. BALANCE DUE $ XX.XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
I.M. Provider MM/DD/YY
SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
I.M. Nursing Home
506 Willow
Anytown, WI 55555

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
I.M. Billing
1 W. Williams
Anytown, WI 55555 87654300
PIN# GRP#

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** FORM HCFA 1500 (12 90) FORM OWCP-1500 FORM RRB-1500

Appendix 1b
National HCFA 1500 Claim Form Completion Instructions for Occupational Therapy Services and Rehabilitation Agencies

Use these claim form completion instructions to avoid denial or inaccurate claim payment. Enter all required data on the claim form in the appropriate element. Include attachments only when requested. All elements are required unless "not required" is specified.

Medicaid recipients receive an identification card when initially enrolled into Wisconsin Medicaid and at the beginning of each following month. Providers should always see this card before providing services. Please use the information exactly as it appears on the identification card to complete the patient and insured information.

Element 1 - Program Block/Claim Sort Indicator
Enter the claim sort indicator:

"T" - Occupational Therapy Services.
"M" - Rehabilitation Agency.

Claims submitted without this indicator are denied.

Element 1a - Insured's I.D. Number
Enter the recipient's 10-digit identification number from the current identification card. This element must contain no other numbers, unless the claim is a Medicare crossover claim, in which case the recipient's Medicare number may also be indicated.

Element 2 - Patient's Name
Enter the recipient's last name, first name, and middle initial from the current identification card.

Element 3 - Patient's Birth Date, Patient's Sex
Enter the recipient's birth date in MM/DD/YY format (i.e., February 3, 1955, would be 02/03/55) from the identification card. Specify if male or female with an "X."

Element 4 - Insured's Name (not required)

Element 5 - Patient's Address
Enter the complete address of the recipient's place of residence.

Element 6 - Patient Relationship to Insured (not required)

Element 7 - Insured's Address (not required)

Element 8 - Patient Status (not required)

Element 9 - Other Insured's Name
You must bill health insurance (commercial insurance coverage) prior to billing Wisconsin Medicaid unless the service does not require health insurance billing according to Appendix 18a of Part A, the all-provider handbook. Leave this element blank when:

1. The provider has not billed health insurance because the "Other Coverage" of the recipient's Medicaid identification card is blank.

2. The service does not require health insurance billing according to Appendix 18a of Part A, the all-provider handbook.

3. The recipient's Medicaid identification card indicates "DEN" only.

4. You must indicate one of the following codes in the first box of element 9 when "Other Coverage" of the recipient's Medicaid identification card indicates HPP, BLU, WPS, CHA, or OTH, and the service requires health insurance billing according to Appendix 18a of Part A, the all-provider handbook. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.):

Code	*Description*
OI-P	Use the OI-P disclaimer code when the health insurance pays in part. The claim indicates the amount paid by the health insurance company to the provider or the insured.
OI-D	Use the OI-D disclaimer code only when these three criteria are met: ◆ The "Other Coverage" field on the recipient's ID card shows HPP, BLU, WPS, CHA, DEN, or OTH. ◆ The service requires billing health insurance before Wisconsin Medicaid. ◆ You have billed the health insurance and received a denial from the insurance company.
OI-Y	Use the OI-Y disclaimer code when the card indicates other coverage but it was not billed for reasons including: ◆ The provider knows the service in question is noncovered by the insurer. ◆ Insurance failed to respond to a follow-up claim. ◆ When "Other Coverage" of the recipient's Medicaid identification card indicates "HMO" or "HMP," one of the following disclaimer codes must be indicated if applicable:

Code	*Description*
OI-P	Use the OI-P disclaimer code when the health insurance pays in part. The amount paid is indicated on the claim.
OI-H	Use the OI-H disclaimer code only when these two criteria are met: ◆ The "Other Coverage" field on the recipient's ID card is HMO or HMP. ◆ The HMO or HMP does not cover the service or the billed amount does not exceed the coinsurance or deductible amount.

Note: You may *not* use OI-H if the HMO or HMP denied payment because an otherwise covered service was not rendered by a designated provider. Wisconsin Medicaid does not reimburse services covered by an HMO or HMP except for the copayment and deductible amounts. Providers who receive a capitation payment from the HMO may not bill Wisconsin Medicaid for services which are included in the capitation payment.

Element 10 - Is Patient's Condition Related to (not required)

Element 11 - Insured's Policy, Group, or FECA Number

Use the *first* box of this element for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Medicare must be billed before billing Wisconsin Medicaid. When the recipient's identification card indicates Medicare coverage, but Medicare does not pay, indicate one of the following Medicare disclaimer codes. The description is not required.

Code	*Description*

M-1 Medicare benefits exhausted. This code applies when Medicare has denied the claim because the recipient's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted.

Use M-1 in these two instances only:

For Medicare Part A (all three criteria must be met):

- The provider is certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The procedure provided is covered by Medicare Part A but is denied due to benefits being exhausted.

For Medicare Part B (all three criteria must be met):

- The provider is certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The procedure provided is covered by Medicare Part B but is denied due to benefits being exhausted.

M-5 Provider not Medicare certified. This code applies when the provider is not required by Wisconsin Medicaid to be Medicare Part A or Part B certified, has chosen not to be Medicare Part A or Part B certified, or cannot be Medicare Part A or Part B certified.

Use M-5 in these two instances only:

For Medicare Part A (all three criteria must be met):

- The provider is not certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The service is covered by Medicare Part A.

For Medicare Part B (all three criteria must be met):

- The provider is not certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The service is covered by Medicare Part B.

M-6 Recipient not Medicare eligible. This code applies when Medicare denied the claim because there is no record of the recipient's eligibility. Use M-6 in these two instances only:

For Medicare Part A (all three criteria must be met):

- The provider is certified for Medicare Part A.
- The service is covered by Medicare Part A.
- The recipient is not eligible for Medicare Part A.

For Medicare Part B (all three criteria must be met):

- The provider is certified for Medicare Part B.

- The service is covered by Medicare Part B.
- The recipient is not eligible for Medicare Part B.

M-7 Medicare disallowed or denied payment. This code applies when Medicare actually denies the claim for reasons given on the Medicare remittance advice. Use M-7 in these two instances only:

For Medicare Part A (all three criteria must be met):
- The provider is certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The service is covered by Medicare Part A but is denied by Medicare Part A.

For Medicare Part B (all three criteria must be met):
- The provider is certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The service is covered by Medicare Part B but is denied by Medicare.

M-8 Noncovered Medicare service. This code applies when Medicare was not billed because Medicare does not cover the service at this time. A list of services that are not covered under Medicare is in Appendix 16 of Part A, the all-provider handbook.

Nursing homes must use M-8 for Medicare-eligible recipients who are hospitalized and do not wish to return to a Medicare-covered bed.

For Medicare Part A (all three criteria must be met):
- The provider is certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The service is not covered under Medicare Part A.

For Medicare Part B (all three criteria must be met):
- The provider is certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The service is not covered under Medicare Part B.

Leave the element blank if Medicare is not billed because the recipient's Medicaid identification card indicated no Medicare coverage.

Leave the element blank if Medicare allows an amount on the recipient's claim. Attach the Explanation of Medicare Benefits (EOMB) to the claim. Do not enter Medicare paid amounts on the claim form. Refer to Appendix 17 of Part A, the all-provider handbook, for more information about the submission of claims for dual-entitlees.

Elements 12 and 13 - Authorized Person's Signature
(Not required since the provider automatically accepts assignment through Medicaid certification.)

Element 14 - Date of Current Illness, Injury, or Pregnancy (not required)

Element 15 - If Patient Has Had Same or Similar Illness (not required)

Element 16 - Dates Patient Unable to Work in Current Occupation (not required)

Element 17 - Name of Referring Physician or Other Source
Enter the referring or prescribing physician's name.

Element 17a - I.D. Number of Referring Physician
Enter the referring provider's six-character UPIN number. If the UPIN number is not available, enter the Medicaid provider number or license number of the referring provider. Refer to Appendix 3 of Part A, the all- provider handbook, for the UPIN directory address.

Element 18 - Hospitalization Dates Related to Current Services (not required)

Element 19 - Reserved for Local Use
If an unlisted procedure code is billed, describe the procedure. If element 19 does not provide enough space for the procedure description, or if multiple unlisted procedure codes are being billed, attach documentation to the claim describing the procedure(s). In this instance, indicate "See Attachment" in element 19.

Element 20 - Outside Lab (not required)

Element 21 - Diagnosis or Nature of Illness or Injury
Enter *The International Classification of Diseases, 9th Revision, Clinical Modification* (ICD-9-CM) diagnosis code for each symptom or condition related to the services provided. Manifestation ("M") codes are not acceptable. List the primary diagnosis first. Etiology ("E") codes may not be used as a primary diagnosis.

Element 22 - Medicaid Resubmission (not required)

Element 23 - Prior Authorization
Enter the seven-digit prior authorization number from the approved prior authorization request form. Bill services authorized under multiple prior authorizations on separate claim forms with their respective prior authorization numbers.

Element 24a - Date(s) of Service
Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one date of service, enter the date in MM/DD/YY format in the "From" field.
- When billing for two, three, or four dates of service on the same line, enter the first date of service in MM/DD/YY format in the "From" field, and subsequent dates of service in the "To" field by listing *only* the date(s) of the month (e.g., DD, DD/DD, or DD/DD/DD).

It is allowable to enter up to four dates of service per line if:

- All dates of service are in the same calendar month.
- All services are billed using the same procedure code and modifier if applicable.
- All procedures have the same type of service code.
- All procedures have the same place of service code.
- All procedures were performed by the same provider.
- The same diagnosis is applicable for each procedure.
- The charge for each procedure is identical. (Enter the total charge *per detail line* in element 24f.)
- The number of services performed on each date of service is identical.
- All procedures have the same HealthCheck indicator.
- All procedures have the same emergency indicator.

Element 24b - Place of Service
Enter the appropriate *single-digit* place of service code for each service. Refer to Appendix 3 of this handbook for a list of allowable place of service codes for occupational therapy services.

Element 24c - Type of Service Code
Enter the appropriate single-digit type of service code. Refer to Appendix 3 of this handbook for a list of allowable type of service codes for occupational therapy services.

Element 24d - Procedures, Services, or Supplies
Enter the appropriate five-character procedure code and, if applicable, a maximum of two, two-character modifiers. Refer to Appendix 4 of this handbook for a list of allowable procedure codes for occupational therapy services.

Element 24e - Diagnosis Code
When multiple procedures related to different diagnoses are submitted, use column E to relate the procedure performed (element 24d) to a specific diagnosis in element 21. Enter the number (1, 2, 3, or 4) which corresponds to the appropriate diagnosis in element 21.

Element 24f - Charges
Enter the total charge for each line.

Element 24g - Days or Units
Enter the total number of services billed for each line. Occupational therapy services must be billed following the *Conversion of Therapy Treatment Time Guidelines* in Appendix 5 of this handbook.

Element 24h - EPSDT/Family Planning
Enter an "H" for each procedure that was performed as a result of a HealthCheck (EPSDT) referral. If HealthCheck does not apply, leave this element blank.

Element 24i - EMG
Enter an "E" for *each* procedure performed as an emergency regardless of the place of service. If the service is not an emergency, leave this element blank.

Element 24j - COB (not required)

Element 24k - Reserved for Local Use
Enter the eight-digit provider number of the performing provider *for each procedure* if it is different than the billing provider number indicated in element 33.

Note: Rehabilitation agencies do not indicate a performing provider number.

When applicable, enter the word "spenddown" and under it, enter the spenddown amount on the last detail line of element 24k directly above element 30. Refer to Section IX of Part A, the all-provider handbook, for information on recipient spenddown.

Any other information entered in this column may cause claim denial.

Element 25 - Federal Tax ID Number (not required)

Element 26 - Patient's Account No.
Optional - The provider may enter up to 12 characters of the patient's internal office account number. This number appears on the fiscal agent Remittance and Status Report.

Element 27 - Accept Assignment
Not required. Provider automatically accepts assignment through Medicaid certification.

Element 28 - Total Charge
Enter the total charges for this claim.

Element 29 - Amount Paid
Enter the amount paid by the health insurance. If the other health insurance denied the claim, enter $0.00. (If a dollar amount is indicated in element 29, "OI-P" must be indicated in element 9.)

Element 30 - Balance Due
Enter the balance due as determined by subtracting the recipient spenddown amount in element 24k and the amount paid in element 29 from the amount in element 28.

Element 31 - Signature of Physician or Supplier
The provider or an authorized representative must sign in element 31. Also enter the month, day, and year the form is signed in MM/DD/YY format.

Note: This may be a computer-printed or typed name and date, or a signature stamp with the date.

Element 32 - Name and Address of Facility Where Services Rendered
If the services were provided to a recipient in a nursing home (place of service 7 or 8), indicate the nursing home's eight-digit provider number.

Element 33 - Physician's, Supplier's Billing Name, Address, Zip Code, and Telephone
Enter the billing provider's name (exactly as indicated on the provider's notification of certification letter) and address. At the bottom of element 33, enter the billing provider's eight-digit provider number.

Appendix 2
Electronic Media Claims Screen

WELCOME TO ELECTRONIC CLAIMS SUBMISSION DATE 010193
EDS - WISCONSIN MEDICAID

BP NBR 33 L NAME 2 F NAME 2 MID 1A
PCN 26 OI 9 TPL 10 MSC 11 PA NBR 23
RP NBR 17 FP NBR 32 OP NBR
DIAG 1 21.1 2 21.2 3 21.3 4 21.4 5

DTL	FDOS	A1A2A3	POS	PROC	M1	M2	PP NBR	DX	CHARGE	UNIT	TOS	EMG	H/F
1	24A	A	B	D	D	D	K	E	F	G	C	I	H
2													
3													
4													
5													
6													
7													
8													
9													
10													

TOT BILL 28 OI PAID 29 PAT PAID 24K NET BILL 30

Doc #1 Page #1 Field #6 Form: MEDVENDR 01-01-1993 10:17:35

Benefits of Electronic Claim Submission

One of the greatest benefits of electronic claim submission is that less information from providers is required for processing. Less information means less room for error. The data elements *not* required on electronic claims include the following:

- ✓ Claim sort indicator.
- ✓ Patient's address.
- ✓ Patient's date of birth.
- ✓ Signature of provider.
- ✓ Patient's sex.
- ✓ Provider's name and address.

Other benefits of billing electronically include the following:

- ✓ Free software.
- ✓ Improved cash flow.
- ✓ Online edits.
- ✓ Lower detail denial rate.
- ✓ Flexible submission methods.
- ✓ Claim entry controlled by provider.

To request more information on electronic claims submission contact the Electronic Media Claims (EMC) Department at the address located in Section IV of this handbook.

Appendix 3
Wisconsin Medicaid
Place of Service and Type of Service Codes
for Occupational Therapy Services

Billing on the HCFA 1500 Form

Wisconsin Medicaid Allowable Place of Service (POS) Codes	
POS Code	**Description**
0	Other
3	Office (including services off the licensed hospital location)
4	Home
7	Nursing Home
8	Skilled Nursing Facility

Wisconsin Medicaid Allowable Type of Service (TOS) Codes	
TOS Code	**Description**
1	Medical (Occupational Therapy Services)
9	Rehabilitation Agency Services

Appendix 4
Wisconsin Medicaid Allowable Current Procedural Terminology and HCPCS Procedure Codes and Copayments for Occupational Therapy Services

Allowable Types and Places of Service for Specific Service Providers	
Rehabilitation Agencies [Type of Service (TOS) = 9]	Independent Therapists, Therapy Groups, and Therapy Clinics [Type of Service (TOS) = 1]
Allowable Places of Service = 0, 3, 4, 7, 8	Allowable Places of Service = 0, 3, 4, 7, 8

Modalities

CPT Procedure Code	Description	Copayment for CPT/ HCPCS Code	Daily Service Limit	Procedure Allowable for Therapy Assistants
90901	Biofeedback training by any modality (15 minutes)	$2.00	Not Applicable	Allowed
97010	Application of a modality to one or more areas; hot or cold packs (15 minutes)	$1.00	1 per day	Allowed
97018	Application of a modality to one or more areas; paraffin bath (15 minutes)	$1.00	1 per day	Allowed
97034	Application of a modality to one or more areas; contrast baths (15 minutes)	$0.50	Not Applicable	Allowed

Therapeutic Procedures

CPT Procedure Code	Description	Copayment for CPT/ HCPCS Code	Daily Service Limit	Procedure Allowable for Therapy Assistants
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility	$1	Not applicable	Allowed
97112	Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception	$1	Not Applicable	Allowed
97124	Therapeutic procedure, one or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)	$1	Not Applicable	Allowed
97139	Therapeutic procedure, one or more areas, each 15 minutes; unlisted therapeutic procedure (specify)	$1	Not Applicable	Allowed
97150	Therapeutic procedure(s), group (2 or more individuals) (each 15 minutes)	$0.50	Not Applicable	Allowed
97250	Myofascial release/soft tissue mobilization, one or more regions (15 minutes)	$1	Not applicable	Not Allowed
97265	Joint mobilization, one or more areas (peripheral or spinal) (15 minutes)	$2	1 per day	Not Allowed
97520	Prosthetic training; upper and/or lower extremities, each 15 minutes	$1	Not Applicable	Allowed
97530	Therapeutic activities, direct (one-on-one) patient contract by the provider (use of dynamic activities to improve functional performance), each 15 minutes	$1	Not Applicable	Allowed
97535	Self care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions of adaptive equipment) direct one-on-one contact by the provider, each 15 minutes	$1	Not Applicable	Allowed
97542	Wheelchair management, propulsion training, each 15 minutes	$1	Not Applicable	Allowed

Other Procedures

CPT Procedure Code	Description	Copayment for CPT/ HCPCS Code	Daily Service Limit	Procedure Allowable for Therapy Assistants
97770	Development of cognitive skills to improve attention, memory, problem solving, including compensatory training and/or sensory integrative activites, direct (one-on-one) patient contact by the provider, each 15 minutes	$1	Not Applicable	Allowed

Comprehensive Evaluation

CPT Procedure Code	Description	Copayment for CPT/ HCPCS Code	Daily Service Limit	Procedure Allowable for Therapy Assistants
97003	Occupational therapy evaluation (15 minutes)	$1	Not Applicable	Not Allowed
97004	Occupational therapy re-evaluation (15 minutes)	$0.50	2 per day	Not Allowed